

# Clinical Policy: Caudal or Interlaminar Epidural Steroid Injections

Reference Number: CP.MP.164

Last Review Date: 08/19

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## Description

Epidural steroid injections have been used for pain control in patients with radiculopathy, spinal stenosis, and nonspecific low back pain, despite inconsistent results as well as heterogeneous populations and interventions in randomized trials. Epidural injections are performed utilizing three approaches in the lumbar spine: caudal, interlaminar, and transforaminal. Generally, candidates for epidural steroid injection are individuals who have acute radicular symptoms or neurogenic claudication unresponsive to traditional analgesics and rest, with significant impairment in activities of daily living.

## Policy/Criteria

It is the policy of health plans affiliated with Centene Corporation<sup>®</sup> that invasive pain management procedures performed by a physician are **medically necessary** when *the relevant criteria are met, only one procedure is performed per visit, with or without radiographic guidance, and the member is not currently being treated with full anticoagulation therapy. If on warfarin, international normalized ratio (INR) should be  $\leq 1.4$  prior to the procedure.*

Discontinuing anti-platelet therapy is a clinical decision balancing risks and benefits of the procedure on therapy, versus the underlying medical condition if not treated appropriately.

- I. It is the policy of health plans affiliated with Centene Corporation<sup>®</sup> that caudal or interlaminar epidural steroid injections (ESIs) are **medically necessary** for the following indications:
  - A. *One caudal or interlaminar ESI for acute pain management (pain lasting < 3 months) when all of the following are met:*
    1. There is severe radicular pain that interferes substantially with activities of daily living (ADLs);
    2. Severe pain persists after treatment with nonsteroidal anti-inflammatory drugs (NSAID) and/or opiates (both  $\geq 3$  days or contraindicated/not tolerated);
    3. The member cannot tolerate chiropractic or physical therapy and the injection is intended as a bridge to therapy.
  - B. *Initial ESI for chronic pain, all of the following:*
    1. Request is for one caudal or interlaminar ESI at one level in the cervical, thoracic or lumbar region;
    2. Persistent radicular pain has been caused by spinal stenosis, disc herniation or degenerative changes in the vertebrae, as confirmed by physical exam and imaging;
    3. Pain interferes with ADLs and has lasted for at least 3 months;
    4. The member has failed to respond to conservative therapy including all of the following:
      - a.  $\geq 6$  weeks chiropractic, physical therapy or prescribed home exercise program;
      - b. NSAID  $\geq 3$  weeks or NSAID contraindicated or not tolerated;

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- c.  $\geq 6$  weeks activity modification.
  - C. *Second caudal or interlaminar ESI for chronic pain that **did not** improve from the first ESI, all of the following:*
    - 1. Request is for an ESI at one level in the cervical, thoracic or lumbar region;
    - 2. At least 2 weeks have passed since the first ESI.
  - D. *Subsequent caudal or interlaminar ESI for recurrence of chronic pain that **had improved** from the first or second ESI, all of the following:*
    - 1. Initial injection(s) led to  $\geq 50\%$  relief and functional improvement for at least 2 months;
    - 2. At least 2 months have passed since the last ESI;
    - 3. Less than 4 injections have been administered within 12 months;
    - 4. Less than 12 months have elapsed since the initial injection at the level requested.
- II. It is the policy of health plans affiliated with Centene Corporation that *a third or subsequent caudal or interlaminar ESI for chronic pain that **did not** improve from the first two ESIs is considered **not medically necessary*** because effectiveness has not been established.
- III. It is the policy of health plans affiliated with Centene Corporation that *continuation of injections beyond 12 months or more than 4 therapeutic injections is considered **not medically necessary*** because effectiveness and safety have not been established. When more definitive therapies cannot be tolerated or provided, consideration will be made on a case by case basis.
- IV. It is the policy of health plans affiliated with Centene Corporation that *caudal or interlaminar ESI for any other indication or location is considered **not medically necessary*** because effectiveness has not been established.

#### Background

There is much debate on the efficacy and medical necessity of multiple interventions for managing spinal pain. Epidural glucocorticoid injections have been used for pain control in patients with radiculopathy, spinal stenosis, and nonspecific low back pain despite inconsistent results as well as heterogeneous populations and interventions in randomized trials. Epidural injections are performed utilizing 3 approaches in the lumbar spine: caudal, interlaminar, and transforaminal. Generally, candidates for epidural steroid injection are individuals who have acute radicular symptoms or neurogenic claudication unresponsive to traditional analgesics and rest, with significant impairment in activities of daily living. Epidural steroid injections have been used in the treatment of spinal stenosis for many years, and no validated long-term outcomes have been reported to substantiate their use. However, significant improvement in pain scores, have been reported at 3 months.

Zhai et al<sup>1</sup> conducted a meta-analysis to assess the effects of various surgical and nonsurgical modalities, including epidural injections, used to treat lumbar disc herniation (LDH) or radiculitis. A systematic literature search was conducted to identify RCTs which compared the effect of local anesthetic with or without steroids. The outcomes included pain relief, functional

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improvement, opioid intake, and therapeutic procedural characteristics. The reviewers concluded the meta-analysis confirms that epidural injections of local anesthetic with or without steroids have beneficial but similar effects in the treatment of patients with chronic low back and lower extremity pain.

Results of a 2 year follow-up of 3 randomized, double-blind, controlled trials, with a total of 360 patients with chronic persistent pain of disc herniation receiving either caudal, lumbar interlaminar or transforaminal epidural injections, showed similar efficacy of the 3 techniques with local anesthetic alone or local anesthetic with steroid. Caudal and interlaminar trials used in the assessment showed some superiority of steroids over local anesthetic, at 3 and 6 month follow-up. Interlaminar with steroids were superior to transforaminal at 12-months.<sup>2</sup>

**Coding Implications**

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CPT® Codes	Description
62320	Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, cervical or thoracic; without imaging guidance
62321	Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, cervical or thoracic; with imaging guidance (ie, fluoroscopy or CT)
62322	Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); without imaging guidance
62323	Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); with imaging guidance (ie, fluoroscopy or CT)
62324	Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, cervical or thoracic; without imaging guidance
62325	Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic,

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<b>CPT® Codes</b>	<b>Description</b>
	antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, cervical or thoracic; with imaging guidance (ie, fluoroscopy or CT)
62326	Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); without imaging guidance
62327	Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); with imaging guidance (ie, fluoroscopy or CT)

<b>HCPCS Codes</b>	<b>Description</b>
N/A	

**ICD-10-CM Diagnosis Codes that Support Coverage Criteria**

+ Indicates a code requiring an additional character

<b>Code</b>	<b>Description</b>
M47.22	Other spondylosis with radiculopathy, cervical region
M47.23	Other spondylosis with radiculopathy, cervicothoracic region
M47.24	Other spondylosis with radiculopathy, thoracic region
M47.25	Other spondylosis with radiculopathy, thoracolumbar region
M47.26	Other spondylosis with radiculopathy, lumbar region
M47.27	Other spondylosis with radiculopathy, lumbosacral region
M48.00-M48.08	Spinal Stenosis
M50.10-M50.13	Cervical disc disorder with radiculopathy
M51.14-M51.17	Thoracic, thoracolumbar and lumbosacral intervertebral disc disorders with radiculopathy
M54.12	Radiculopathy, cervical region
M54.13	Radiculopathy, cervicothoracic region
M54.14	Radiculopathy, thoracic region
M54.15	Radiculopathy, thoracolumbar region
M54.16	Radiculopathy, lumbar region
M54.17	Radiculopathy, lumbosacral region
M54.5	Low back pain
M54.6	Pain in thoracic spine
M96.1	Postlaminectomy syndrome, not elsewhere classified

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Reviews, Revisions, and Approvals	Date	Approval Date
Caudal and interlaminar ESI criteria reviewed in CP.MP.118	04/18	04/18
Split from CP.MP.118 Injections for Pain Management. No criteria changes.	08/18	
In section D regarding second or subsequent ESI for chronic pain that improved from the diagnostic injections, changed requirement for 3 months having passed from the previous injection to 2 months. Anticoagulation indication moved to policy/criteria section as it is applicable to all injections in this policy.	08/19	08/19

**References**

1. Zhai J, Zhang L, Li M, et al. Epidural injection with or without steroid in managing chronic low back and lower extremity pain: a meta-analysis of ten randomized controlled trials. *Int J Clin Exp Med*. 2015 Jun 15;8(6):8304-16. eCollection 2015.
2. Manchikanti L, Singh V, Pampati V, et al. Comparison of the efficacy of caudal, interlaminar, and transforaminal epidural injections in managing lumbar disc herniation: is one method superior to the other? *Korean J Pain*. 2015 Jan;28(1):11-21.
3. American College of Occupational and Environmental Medicine Guidelines: Chronic Pain. ACOEM 2008.
4. Chou R, Hashimoto R, Friedly J, Fu Rochelle, Dana T, Sullivan S, Bougatsos C, Jarvik J. Pain Management Injection Therapies for Low Back Pain. Technology Assessment Report ESIB0813. (Prepared by the Pacific Northwest Evidence-based Practice Center under Contract No. HHS 290-2012-00014-I.) Rockville, MD: Agency for Healthcare Research and Quality; March 2015.
5. Chou R. Subacute and chronic low back pain: Nonsurgical interventional treatment. In: *UpToDate, Atlas SJ (Ed), UpToDate, Waltham, MA*. Accessed 8/6/19.
6. Chou R, et al. Diagnosis and treatment of low back pain: a joint clinical practice guideline from the American College of Physicians and the American Pain Society. *Ann Intern Med*. 2007;147:478-491.
7. Chou R et al. Interventional therapies, surgery, and interdisciplinary rehabilitation for low back pain. An evidence-based clinical practice guideline from the American Pain Society. *Spine* 2009; 34: 1066-1077.
8. Chou R, Hashimoto R, Friedly J, et al. Epidural Corticosteroid Injections for Radiculopathy and Spinal Stenosis: A Systematic Review and Meta-analysis. *Annals Of Internal Medicine*, 163(5), 373-381. doi:10.7326/M15-0934
9. Heggeness MH. AAOS endorses back pain guidelines. *AAOS Now*. Sept 2010.
10. Manchikanti L et al. A Critical Review of the American Pain Society Clinical Practice Guidelines for Interventional Techniques: Part 1. Diagnostic Interventions. *Pain Physician* 2010; 13:E141-E174.
11. Manchikanti L et al. A Critical Review of the American Pain Society Clinical Practice Guidelines for Interventional Techniques: Part 2. Therapeutic Interventions. *Pain Physician* 2010; 13:E215-E264.
12. Manchikanti L, Abdi S, Atluri S, et al. An update of comprehensive evidence-based guidelines for interventional techniques in spinal pain. Part II: guidance and recommendations. *Pain Physician* 2013; 16: S49-S283.

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13. Novak S, Nemeth WC. The basis for recommending repeating epidural steroid injections for radicular low back pain: a literature review. *Arch Phys Med Rehabil* 2008; 89:543-552.
14. Sharma AK, Vorobeychik Y, Wasserman R, et al. The Effectiveness and Risks of Fluoroscopically Guided Lumbar Interlaminar Epidural Steroid Injections: A Systematic Review with Comprehensive Analysis of the Published Data. *Pain Med*. 2016.
15. Staal JB et al. Injection therapy for subacute and chronic low-back pain. *Cochrane Database of Systematic Reviews* 2008, Issue 3. Art. No. CD001824. DOI: 10.1002/14651858.CD001824.pub3.
16. Vorobeychik Y, Sharma A, Smith CC, et al. The Effectiveness and Risks of Non-Image-Guided Lumbar Interlaminar Epidural Steroid Injections: A Systematic Review with Comprehensive Analysis of the Published Data. *Pain Med*. 2016.
17. Work Loss Data Institute. Low back – lumbar & thoracic (acute & chronic). Encinitas (CA): Work Loss Data Institute; 2011. Various p.
18. Hayes Medical Technology Directory. Epidural Steroid Injections for Low Back Pain and Sciatica. Jan 2013. Update Jan. 2017. Archived Mar. 2018.
19. Kreiner DS, Hwang S, Easa J, et al. An evidence-based clinical guideline for the diagnosis and treatment of lumbar disc herniation with radiculopathy. *Spine J*. 2014 Jan;14(1):180-91. doi: 10.1016/j.spinee.2013.08.003. Epub 2013 Nov 14
20. Smith CC, Booker T, Schaufele MK, Weiss P. Interlaminar versus transforaminal epidural steroid injections for the treatment of symptomatic lumbar spinal stenosis. *Pain Med*. 2010 Oct;11(10):1511-5.
21. Schaufele MK, Hatch L, Jones W. Interlaminar versus transforaminal epidural injections for the treatment of symptomatic lumbar intervertebral disc herniations. *Pain Physician*. 2006 Oct;9(4):361-6.
22. Chang-Chien GC, Knezevic NN, McCormick Z, et al. Transforaminal versus interlaminar approaches to epidural steroid injections: a systematic review of comparative studies for lumbosacral radicular pain. *Pain Physician*. 2014 Jul-Aug;17(4):E509-24.

**Important Reminder**

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

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contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

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**Note: For Medicare members,** to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at <http://www.cms.gov> for additional information.

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